Alliance of Independent Academic Medical Centers’ National Initiative:

Resource Document

Handoffs

August 20, 2008
Handoffs Resources

This document contains Web Resources and a bibliography of over 270 articles divided into the following categories (page numbers for section starts are in parentheses after each category name): General Hand-offs (3), Nursing Hand-offs (US) (4), Nursing Hand-offs (non-US) (8), Physician Hand-offs (US) (11), Physician Hand-offs (all levels, non US) (12), Resident Hand-offs (US) (13), Handoff Mnemonics, excluding SBAR (15), SBAR Handoff Mnemonics (16), and Joint Commission Requirement (17).


Description: An article describing techniques for improving patient hand-offs.

Description: This Web page includes a 2007 report that contains comparative results on 108,621 hospital staff respondents from 382 participating hospitals that administered the AHRQ Hospital Survey on Patient Safety Culture. In the appendixes. The results are broken down by hospital characteristics (bed size, teaching status, ownership and control, region) and respondent characteristics (hospital work area/unit, staff position, interaction with patients). The Survey was designed to assess hospital staff opinions about patient safety issues, medical error, and event reporting; it includes 42 items that measure 12 areas or composites of patient safety culture: 1. Communication openness; 2. Feedback and communication about error; 3. Frequency of events reported; 4. Handoffs and transitions; 5. Management support for patient safety; 6. Nonpunitive response to error; 7. Organizational learning/continuous improvement; 8. Overall perceptions of patient safety; 9. Staffing; 10. Supervisor/manager expectations and actions promoting safety; 11. Teamwork across units; 12. Teamwork within units.
Excellent source for comparative data on handoffs and transitions. The Web page also includes the actual survey and other resources.

Description: 174 page textbook published by HCPro, Inc. that costs $149.00. ISBN # is 157839788X.

Description: Audioconference on tape or CD that costs $249.00. A 90-minute audioconference from HCPro, designed to ensure you are in compliance with JCAHO’s National Patient Safety Goal #2E.

Description: AORN and the U.S. Department of Defense Patient Safety Program collaboratively developed this Web-based tool kit that provides the resources to guide perioperative professionals in standardizing hand-off communications among caregivers. The tool kit, based on the Department of Defense Patient Safety Program TeamSTEPPSTM initiative, will help develop consistency in communications needed for effective patient care.

The AORN Patient Hand-Off Tool Kit includes supporting research for evidence-based recommendations on perioperative patient hand offs, sample checklists and forms,
PowerPoint presentations on standardizing communication and information exchanges in perioperative practice, and an annotated guide to additional resources. These resources are free.

  
  Description: Contains a brief description of SBAR (Situation-Background-Assessment-Recommendation) technique, which provides a framework for communication between members of the health care team about a patient’s condition; a list of related literature; and the SBAR card.

  
  Description: Article that describes five strategies for improving hand-off communication.

  
  Description: Web-based case presentation.

**Articles**

**General Hand-offs**


Wilcox RA, La Tella RR. The personal digital assistant, a new medical instrument for the exchange of clinical information at the point of care. Medical Journal of Australia 2001;175(11-12):659-662.

**Nursing Hand-offs (US)**
Anonymous. AORN offers handoff toolkit. OR Manager 2007;23(6):32.
Anonymous. JCAHO to look closely at patient handoffs: Communication lapses will be key focus. Hospital Case Management 2006;14(1):9-10. – same as above article
Anonymous. Patient handoffs don’t have to be high risk. RN 2006;69(8):20hfl.
Anonymous. Patients at this hospital have a ‘ticket to ride’: Handoff problem addressed with form. *Case Management Advisor* 2006;17(10):116-117.


Groah L. Tips for introducing SBAR in the OR. *OR Manager* 2006;22(4):12


**Nursing Hand-offs (non-US)**


Buswell C. All over for handover? *Nursing Standard* 1994;8(31):44.


Connor D. Patient-led handovers should be encouraged. *Nursing Standard* 2006;21(10):32.


Dowding D. Examining the effects that manipulating information given in the change of shift report has on nurses’ care planning ability. *Journal of Advanced Nursing* 2001;33(6):836-846.


Hoban V. How to ... handle a handover. *Nursing Times* 2003;99(9):54-55.


Howell M. Confidentiality during staff reports at the bedside. *Nursing times* 1994;90(34):44-45.


Manias E, Street, A. The handover: Uncovering the hidden practices of nurses. *Intensive & Critical Care Nursing* 2000;16(6), 373-383.


Van de Velde V, De Porre J, Leune T, Benoit Y. Changing handover practice: From traditional to bedside handover... 38th Annual Conference of the International Society of Paediatric...
Venamore J. Q and A... no time for a verbal handover and the reports are being audio recorded. Lamp 1999;56(4), 28.
Watkins S. Bedside manners... hand-over reports at patients’ bedsides. Nursing Times 1993;89(29):42-43.

**Physician Hand-offs (US)**


**Physician Hand-offs (all levels, non US)**


Resident Hand-offs (US)


Kushniruk A, Karson T, Moore C, Kannry J. From prototype to production system: Lessons learned from the evolution of the SignOut System at Mount Sinai Medical Center. AMIA ... Annual Symposium Proceedings/AMIA Symposium 2003;381-5.


**Handoff Mnemonics, excluding SBAR**


Ellis D, Mullenhoff P, Ong F. Back to the bedside: Patient safety and handoff report... 2007
Horwitz LI, Moin T, Green ML. Development and implementation of an oral sign-out skills
Kilpack V, Dobson-Brassard S. Intershift report: Oral communication using the nursing process.
*Journal of Neuroscience Nursing* 1987;19(5):266-270.
McCann L, McHardy K, Child S. Passing the buck: Clinical handovers at a New Zealand tertiary
Sandlin D. Improving patient safety by implementing a standardized and consistent approach to
Sutcliffe KM, Lewton E, Rosenthal MM. Communication failures: An insidious contributor to
Talbot R, Bleetman A. Retention of information by emergency department staff at ambulance
Vidyarthi AR, Arora V, Schnipper JL, Wall SD, Wachter RM. Managing discontinuity in
academic medical centers: Strategies for a safe and effective resident sign-out. *Journal of
Hospital Medicine* 2006;1(4):257-266.

**SBAR Handoff Mnemonics**

Ang R. SBAR: A communications framework and technique…situation, background, assessment,
Anonymous. Four tips to meet the handoff goal at your facility. *Briefings on Patient Safety* 2006
Nov:10-11.
Anonymous. Improving handoff communications: meeting National Patient Safety Goal 2E.
Anonymous. Q&A: Implementing the SBAR technique…Situation-Background-Assessment-
Anonymous. SBAR checklist can cut risk at patient handoff. *Healthcare Risk Management*
2006;28(9):102-104.
Anonymous. SBAR checklist outlines what to say at handoff. *Healthcare Risk Management*
2006;28(9):104.
Anonymous. SBAR initiative to improve staff communication. *Healthcare Benchmarks and
Anonymous. The SBAR technique: improves communication, enhances patient
safety…Situation-Background-Assessment-Recommendation. *Joint Comm Perspect Patient
Federwisch A. Passing the baton: bedside shift report ensures quality handoff. *NurseWeek


**Joint Commission Requirement**


Croteau R. JCAHO comments on handoff requirement. OR manager 2005;21(8):8.


**Chapter**

Web Sites
Agency for Healthcare Research and Quality (AHRQ): http://www.ahrq.gov/
Institute for Healthcare Improvement (IHI): http://www.ihi.org/ihi

Acknowledgement
This resource was developed by Jessica Leitzsch for the Alliance of Independent Academic Medical Centers National Initiative: Improving Patient Care through GME members.
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